

# **WOODROW WILSON REHABILITATION CENTER**

## **Field Rehabilitation Services Policy**

### **W.W.R.C. Admissions Criteria**

It is our intention to accept for admission any individual with a disability whose needs are compatible with the structure, staff, and other WWRC resources. Primary consideration is given to DRS clients pursuing vocational goals. For non-DRS referrals, contact the Admissions Department directly for the application process: 540 332-7065.

- Applicants must be medically, physically and psychologically stable and have a favorable prognosis to complete and benefit from the services requested. Applicants with a psychiatric diagnosis must show six (6) consecutive months stability in the community. Exceptions to the six months stability may be considered if the consumer is willing to participate in an outpatient evaluation at WWRC to determine feasibility for services and admission contingencies.

Current documentation from a physician, mental health or other professional providing treatment or diagnostic services may be requested.

Applicants with a history of substance abuse must have six (6) consecutive months of documented abstinence or demonstrated completion of intense substance abuse treatment and active participation in a substance abuse aftercare program (12- step support groups alone do not qualify as intense treatment or aftercare). Exception may be considered if the consumer is willing to participate in an outpatient evaluation at WWRC to determine feasibility for services and admission contingencies.

- Applicant's current behavior will not jeopardize the health, safety, or rehabilitation program of self or others at the Center.
- Applicants must be 18 years of age or older to be admitted for residential services, unless they are requesting a program designed and staffed for minors.
- Applicants must be willing and able to comply with WWRC community living standards (Rules & Regulations).
- Applicants, in conjunction with the referral source, must have a viable plan for community reintegration (discharge plan) addressing residential options as well as community support service needs.

\* \*Applicants are required to have a plan for immediate removal from WWRC if deemed necessary.

- Applicants must have an identified funding source. All funding sources should be identified to the extent possible, especially third party insurers and primary care physicians.
- Applicants must have any court charges against them settled prior to seeking admission. Cases that are pending adjudication through the judicial system will not be considered. WWRC is not an alternative placement option.

## INFORMATION REQUIRED FOR PROCESSING AN APPLICATION FOR ADMISSION

1. WWRC Client Referral Form. (Required for all applications including Outpatient Services.)
2. WWRC Client Application for Admission. (Application process not required for Outpatient Services.)
3. For all clients with active medical/mental health conditions, a recent (within 60 days) medical report from treating physician/clinician is required. If admission is delayed, an updated medical may be required.
4. Psychological reports (including subtest scores) when available; also academic level and counselor administered test results.
5. Social history. This must describe home, family, and community situation. It should also record any information from courts, mental hospitals, or correctional institutions. (DRS-RS4; RS4-0)
6. Educational history, giving academic achievement and school adjustment should be provided for all. For those under 18 years of age who have received special education services, a copy of the most recent eligibility summary and IEP from the LEA needs to be included. (DRS-RS4; RS4-0) If applicant is under 22, final high school transcript is required for pre-vocational and/or vocational training.
7. Work history - as complete as possible. (RS4-0) Employment Plan if applicable.
8. RS-13 and copy of tax return (if available) for individuals under an IPE. If client is not fully funded by DRS for vocational program, RS 15 (WWRC financial participation form) is required.

**\* Additional information may be requested on an individual basis.**

The Woodrow Wilson Rehabilitation Center provides services without discrimination regarding race, color, creed, sex, national origin, age, or disability in compliance with Title VI of the Civil Rights Act of 1964 and the Disability Act of 1990. All applicants have the right to file complaints and to appeal decisions according to regulations governing this process.

## ADMISSION OFFICE CONTACTS AND PHONE NUMBERS: (WWRC 1-800-345-9972 / FAX 540-332-7307)

These staff are available to answer questions about specific programs, next available dates, general criteria, and active referrals.

PHONE  
EMAIL  
@WWRC.Virginia.gov

Program Manager	Greta Hedberg	(540) 332-7052	Greta.Hedberg
Pre-admission Tech – Vocational	Jayne Tooley	(540) 332-7012	Jayne.Tooley
Pre-admission Tech – Vocational	Natasha Benenson	(540) 851-2508	Natasha.Benenson
Pre-admission Tech - Brain Injury Services-STRU	Marjorie Adcock	(540) 332-7493	Marjorie.Adcock
Pre-admission Tech - PERT Offsite Evals	Rita Jones	(540) 332-7015	Rita.Jones
Pre-admission Tech- Outpatient/ Medical Mobile Clinics/Driving	Robyn Jarvis	(540) 332-7948	Robyn.Jarvis
Pre-admission Tech - Outpatient/Medical ART Evals	Joanne Eimers	(540) 332-7017	Joanne.Eimers

## APPEALS PROCESS:

Appeals of WWRC admission decisions shall be addressed through FRS Counselor and Manager review. If the admission is supported by the FRS Manager with supporting documentation, the applicant's denial will be reconsidered by the WWRC admission committee. If resubmitted and denied, the Regional Directors will be consulted through the Operations Committee. The Applicant has the right to file a fair hearing should they choose.

**WOODROW WILSON REHABILITATION CENTER**  
**Fishersville, Virginia 22939**  
**REFERRAL FORM**

**FROM:**

Referral Source: \_\_\_\_\_ Counselor #: \_\_\_\_\_ Date: \_\_\_\_\_

Office/Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Client Name: \_\_\_\_\_ WWRC #: \_\_\_\_\_

Social Security #: \_\_\_\_\_ DRS Case ID#: \_\_\_\_\_

Disability: \_\_\_\_\_ RSA Code (s): \_\_\_\_\_

FAX #: \_\_\_\_\_

This is a: ☐ referral with full DRS sponsorship \*\* Medical insurance will be billed first  
☐ referral with partial DRS sponsorship (Vocational programs only)  
(Client/Family to pay \_\_\_\_\_ % of charges up to \$ \_\_\_\_\_)  
☐ Other ☐ Workman's Comp

DRS status upon arrival at WWRC: \_\_\_\_\_ Days Authorized: \_\_\_\_\_

**Referral: (Goals/Comments)**

**ATTACHMENTS: (INFORMATION REQUIRED FOR PROCESSING ADMISSION APPLICATION)**

- ☐ WWRC Client Application for Admission. (Application process not required for Outpatient Services.)
- ☐ For all clients with active medical/mental health conditions, a recent (within 60 days) medical report from the treating physician/clinician is required. If admission is delayed, an update may be required prior to admission.
- ☐ Psychological reports (including subtest scores) when available; also academic level and counselor administered test results.
- ☐ Social history. This must describe home, family, and community situation. It should also record any information from courts, mental health facilities, or correctional institutions. (DRS-RS4; RS4-0)
- ☐ Educational history, giving academic achievement and school adjustment should be provided for all. For those under age of 18, who have received special education services, a copy of the most recent eligibility summary and IEP from the LEA needs to be included. (DRS-RS4; RS4-0) If applicant is 22 and under, final high school transcript is required.
- ☐ Work history - as complete as possible. (RS4-0)
- ☐ IPE if applicable.
- ☐ RS-13 and copy of tax return (if available) for individuals under an IPE. If client is not fully funded by DRS for vocational program, RS15 (WWRC financial participation form) is required.

- Additional information may be requested on an individual basis.

**PROGRAM REQUESTED:**

- ☐ **Vocational Evaluation**  
☐ Feasibility Interview    ☐ Fast Track    ☐ Work Sample(s)    ☐ Skills Assessment  
☐ Re-Evaluation (under 12 months) Reason? \_\_\_\_\_
- ☐ **Life Skills Transition Program**
- ☐ **Vocational Training**  
Curriculum: \_\_\_\_\_
- ☐ **Brain Injury Services (BIS)** OP Evaluation Clinic – Neuro psychological Evaluation
- ☐ **PERT**                      ☐ Initial Evaluation                      ☐ Situational Assessment (Supplemental)
- ☐ **Short Term Rehabilitation Unit (STRU)**
- ☐ **Outpatient Evaluation**

**SUPPORT SERVICES REQUESTED: (check all that apply)**

- |  |  |
|--|--|
| <input type="checkbox"/> <b>Physical Therapy</b><br><input type="checkbox"/> General Evaluation/Therapy<br><input type="checkbox"/> Wheelchair/Seating Evaluation<br><input type="checkbox"/> Orthotic/Prosthetic Evaluation<br><input type="checkbox"/> Functional Work Capacities Evaluation         | <input type="checkbox"/> <b>Occupational Therapy</b><br><input type="checkbox"/> General Evaluation/Therapy<br><input type="checkbox"/> Independent Living Skills<br><input type="checkbox"/> Visual/Perceptual/Cognitive Skills   |
| <input type="checkbox"/> <b>Communication Services</b><br><input type="checkbox"/> Hearing Evaluation<br><input type="checkbox"/> Speech Evaluation/Therapy<br><input type="checkbox"/> Aphasia/Cognitive Language Eval/Therapy  | <input type="checkbox"/> <b>Behavioral Health</b><br><input type="checkbox"/> Feasibility Interview<br><input type="checkbox"/> Psychological Evaluation<br><input type="checkbox"/> Academic/Intellectual/L.D. Testing<br><input type="checkbox"/> Neuropsychological Testing<br><input type="checkbox"/> Individual Treatment Plan |
| <input type="checkbox"/> <b>Assistive &amp; Rehabilitative Technology</b><br><input type="checkbox"/> Augmentative Communication<br><input type="checkbox"/> Assistive Computer Technology (ACT)<br><input type="checkbox"/> Rehabilitation Engineering<br><input type="checkbox"/> General Evaluation | <input type="checkbox"/> <b>Academic Support Services</b><br><input type="checkbox"/> Adult Basic Education (ABE)<br><input type="checkbox"/> GED Assistance/Prep Test   |
- ☐ **Special Population Services: DBVI & Deaf, Hard of Hearing, ESL**
- ☐ **Other** \_\_\_\_\_
- ☐ **Driving Program**  
☐ Evaluation    ☐ Training    ☐ Adaptive

**RESIDENCE REQUESTED: (check only one)**

- ☐ Attendant Care -- Supported Living Service (SLS) / Short Term Rehab Unit (STRU)
- ☐ Dormitory (can live safely & independently)
- ☐ Day Student

**WOODROW WILSON REHABILITATION CENTER**  
**Fishersville, VA 22939**  
**CLIENT APPLICATION FOR ADMISSION**

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ MIDDLE: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

CLIENT'S \_\_\_\_\_ MARITAL STATUS: S ☐ M ☐ D ☐ W ☐ E ☐  
HOME \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME TELEPHONE #: \_\_\_\_\_

\_\_\_\_\_ CELL PHONE #: \_\_\_\_\_

**EDUCATION:**

☐ Enrolled in school \_\_\_\_\_ Grades completed?

**DIPLOMA** ☐ High School ☐ GED **IEP** ☐ Modified Standard ☐ Completion Certificate

☐ Special Education under 18 (needs I.E.P. & Eligibility summary)

☐ College (How many years completed?) \_\_\_\_\_

**DRIVER'S LICENSE:** ☐ YES ☐ NO

**LEARNER'S PERMIT** ☐ YES ☐ NO

**ORIGIN OF DISABILITY:**

Onset Date: \_\_\_\_\_

Disability related to: ☐ work ☐ crime ☐ home ☐ military ☐ congenital  
☐ sports ☐ motor vehicle ☐ Other \_\_\_\_\_

Is there any legal action pending or contemplated as a result of your injury?: (select one) ☐ YES ☐ NO

Lawyer's Name/Address: \_\_\_\_\_

**LEGAL STATUS:**

Have you been or are you currently: (select one) on probation? ☐ YES ☐ NO

on parole? ☐ YES ☐ NO

awaiting trial on criminal charges? ☐ YES ☐ NO

If you responded YES to any of the above legal status questions, please give details:

**INSURANCE/SPONSORSHIP: (for medically necessary services and/or medical emergencies)**

Do you have medical insurance coverage? ☐ YES ☐ NO

Name of Insurance Company: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Policy/Social Security #: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ Type of Policy: ☐ GROUP ☐ INDIVIDUAL

If Group Policy, please give GROUP #: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

# CLIENT APPLICATION FOR ADMISSION (MEDICAL)

CLIENT NAME: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_

PHYSICIAN'S  
ADDRESS: \_\_\_\_\_

PHYSICIAN'S Telephone#  
Fax # \_\_\_\_\_

**Have you ever been treated by a physician for any of the following?**

	YES	NO
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>

Date of last seizure: \_\_\_\_\_

Infections: MRSA, VRE, TB, OTHER ☐ ☐

Name of infection: \_\_\_\_\_

Other health problems? \_\_\_\_\_

List operations: \_\_\_\_\_

	YES	NO
<b>Do you need a special DIET?</b>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, what type? \_\_\_\_\_

**Have you had a TETANUS SHOT?** ☐ ☐

If yes, when? \_\_\_\_\_

**Do you have any ALLERGIES?** ☐ ☐  
(List any allergies you have to medications, food, etc.)

	YES	NO
<b>Are you taking any MEDICATIONS?</b>	<input type="checkbox"/>	<input type="checkbox"/>

(List the names of the medications you are taking and how many times per day you take them.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Activities of Daily Living:**

	YES	NO
Do you have bowel control?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have bladder control?	<input type="checkbox"/>	<input type="checkbox"/>

Do you need help with:

- eating? ☐ ☐
- dressing? ☐ ☐
- transfers? ☐ ☐
- toileting? ☐ ☐
- bathing? ☐ ☐

Do you use a wheelchair? ☐ ☐

Can you sit in your chair all day? ☐ ☐

Do you have pressure sores?  
(i.e., skin breakdown) ☐ ☐

**Do you have problems with any of the following?**

Speech	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>

**Do you use any of the following assistive devices?**

Glasses	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aid(s)	<input type="checkbox"/>	<input type="checkbox"/>
Walker/crutch/cane	<input type="checkbox"/>	<input type="checkbox"/>
Guide Dog	<input type="checkbox"/>	<input type="checkbox"/>
Blind cane travel	<input type="checkbox"/>	<input type="checkbox"/>
Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>
Orthosis	<input type="checkbox"/>	<input type="checkbox"/>

**Do you have Home Health Services?** ☐ ☐

**How often do you see your physician?**

\_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_

**Clients or their authorized guardian (if applicable) who have existing ADVANCE DIRECTIVES are solely responsible for making this known to the case manager and physician responsible for their care and treatment at WWRC. A copy of the ADVANCE DIRECTIVE must be brought with you and will become a part of the Medical Record.**

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### CONSENT TO ADMISSION/RELEASE OF INFORMATION

I hereby consent to admission to WWRC and give permission to WWRC, its physicians, and staff to administer such treatment, medication, or procedure upon me as they, in their professional judgment, may deem advisable in the care and treatment of my case. I understand that prior to the administration of any treatment, medication, or procedure, I will be advised of the risks and benefits of the proposed treatment, that any questions I have concerning the proposed treatment will be answered and that I have a right to refuse or withdraw consent to the proposed treatment and to discuss the implication of the refusal with my physician (treatment team), including its impact on my health care needs and the ability of WWRC to continue to provide treatment to me. In the event of an emergency, I authorize WWRC to provide such treatment as may be deemed necessary in its professional judgment, to prevent death, serious bodily injury, or serious deterioration in my condition. In an emergency situation requiring surgery, I authorize such surgery to be performed upon me in any qualified hospital to which I may be transferred.

Permission is granted for any physician, psychologist, hospital, school, or other professional or facility to release to the Woodrow Wilson Rehabilitation Center any records concerning me as may be requested by officials of WWRC.

This client application has been fully explained to me and I certify that I understand its contents and it is complete and accurate to the best of my knowledge. A photocopy of this form shall be valid as the original.

Client's Full Name (Please Print): \_\_\_\_\_

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent, Legal Guardian (if under 18 years of age), Power-of-Attorney, or Closest Relative:

X: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**REMOVAL RESPONSIBILITY** – If termination of enrollment becomes necessary, I agree to remove the above-named client from Woodrow Wilson Rehabilitation Center immediately upon notice. (Signature of someone other than applicant required.)

Name (Please Print): \_\_\_\_\_ Home #: \_\_\_\_\_

Address: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

### EMERGENCY NOTIFICATION PERSON: (if different from above)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_